Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315576485M
Compliance #: HL315579783C

Date Concluded: December 30, 2024

Name, Address, and County of Licensee Investigated:
Farmstead Care of Moorhead LP
3200 28th Street S.
Moorhead, MN 56560
Clay County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The resident was neglected when the facility staff failed to provide appropriate care and services when the resident's feeding and gastric tubes were switched around causing the resident to not receive medications, nutrition, or fluids as ordered. As a result, the resident was observed staring blankly and not responding normally.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident's gastric and feeding tubes were observed connected incorrectly, the resident was connected to drainage for only 1 hour, and the resident's change in cognition occurred 2 days prior to when the error was observed. It could not be determined if the resident's change in cognition was the result of the error or related to other possible contributing factors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member.

The investigation included review of the resident record(s), facility internal investigation, grievance, personnel files, text communication and pictures, and related facility policy and procedures. Also, the investigator observed the resident's gastric medication administration and tube feeding services.

The resident resided in an assisted living facility for the last 4 years with diagnoses including neuromuscular weakness, Fahr Syndrome (a neurological disorder which can have symptoms including seizures, poorly articulated speech, and paralysis), severe protein calorie malnutrition, and degenerative disease of the basal ganglia (a condition causing breakdown of nerve cells in the brain that control movement).

The resident's assessment indicated the resident required tube feedings for nutrition and received medication management and administration services from the facility.

The resident's service agreement at the time of the incident indicated the resident received medication administration services 12 times daily, was connected to gastric drainage 4 times daily, and received tube feedings 3 times daily.

The resident services included instruction for staff to verify tube placement of continuous feeding rate 3 times daily and connect the resident to gastric drainage to the port labeled gastric (which faces to the right of the resident's body) every 6 hours for one hour. The services indicated the resident's feeding and gastric tubes were disconnected then reconnected whenever the resident was transferred.

The residents outside medical record indicated the resident had a history of gastric feeding tube malfunction prior to the incident resulting in the gastric feeding tube being replaced 2 times prior to the incident. About 1 month later the resident was hospitalized with COVID-19 and sepsis. The hospital record indicated the resident had feeding intolerance with coughing and vomiting during the hospital stay. The residents discharge summary indicated the resident was tolerating feedings/flushes at the time of discharge but had not returned to baseline.

About 1 week later a nurse's progress note indicated the resident was not at his usual baseline. The note indicated when the nurse assessed the resident his vitals were stable, and the resident was alert/conscious, but not responding to verbal prompts as usual. The note indicated the resident eventually began responding, smiling, and indicated concerns of potential overdose were ruled out, as all medications appeared to be given correctly. The resident's progress notes indicated the family declined to have the resident seen in the emergency department (ED).

A facility grievance form 2 days later indicated the resident's family member texted facility nursing and reported the resident's gastric drainage and feeding tube were connected wrong and corrected the problem immediately. The grievance indicated staff (unknown) told the family member the tubing had been connected that way for a couple of days. A review of the

grievance and text correspondence regarding the incident did not mention any concerns with changes in the resident's cognition at that time.

The resident's Medication Administration Record (MAR) and service delivery record for tube feeding administration, flushes, and connection to gastric drainage showed staff documented completing tasks as ordered and according to the resident's service plan. The day of the incident staff documented tube feeding, gastric drainage, and transfer assistance was provided at 5:46 p.m., indicated the resident's tubing was disconnected for the transfer then reconnected approximately 2 hours prior to when the family member texted to report concerns with the resident's tubes connected incorrectly. There was no indication the resident's tubing was hooked up incorrectly prior to that time.

The resident's progress notes after the incident indicated the resident continued to have recurring increased amounts of feeding into the gastric drainage which was not normal. The notes indicated the resident was seen by a provider who identified the resident's feeding tube was 2/3 clogged resulting in increased pressure which caused the resident's feedings to backup into the gastric drain. The note indicated the resident's gastric feeding tube was replaced again. However, the progress notes indicated following the replacement the resident continued to have concerns with the feeding formula backing up into the gastric drainage tube. The progress notes indicated the resident's provider was contacted who indicated the resident may not be tolerating the current rate of feeding.

When interviewed nursing staff stated they had received a text from the resident's family member who reported the resident's gastric feeding tubes were hooked up incorrectly and corrected the issue. Nursing indicated they could not determine when the tubing was hooked up incorrectly but stated the gastric drain was connected about 2 hours prior to when the family member reported the error in a text. Nursing staff indicated there was no indication the error caused any harm to the resident.

When interviewed the resident's family member stated the resident was observed staring at the ceiling glassy eyed with no response. The family member stated they declined to have the resident seen in the ED because the resident appeared to be coming around (responding/smiling) so they decided to just keep a close eye on him. The family member indicated they did not know the cause of the resident's change in cognition that day and indicated something was wrong, but they could not pinpoint it. Then, 2 days later the family member observed the resident's tubing was hooked up incorrectly.

When interviewed, an unlicensed personnel (ULP) stated he had observed a large amount of the resident's feeding in the gastric drainage 4 days prior to the error reported by family. The ULP stated the tubing at that time was hooked up correctly, and he reported the concern to nursing immediately. The ULP stated the resident appeared lethargic when he disconnected the drain, but it was not unusual for the resident to be sleepy and less responsive at that time of the day. The ULP indicated the resident responded normally the remainder of the day. A review of the

ULP's texted screen shot showed a picture of the drainage bag with milky substance confirmed the ULP timeline and statement of notifying the nurse.

When interviewed leadership nursing indicated although family observed the resident's tubing was hooked up incorrectly, it could not be determined if the incident was related to the resident's change in cognition 2 days prior. Nursing leadership indicated it could not be determined if the change in cognition was related to staff error, issues with the resident's feedings (tubing malfunction/feeding intolerance) or related to his diagnoses and/or recent illness resulting in hospitalization. Nursing leadership stated ongoing concerns with the resident's feeding backing up into his gastric drainage were reported to the resident's provider and a referral was placed for the resident to see a dietician to help manage the resident's tube feedings.

When interviewed the resident stated he remembered the day when his tubing was hooked up wrong causing his feeding to run out, but indicated he felt ok that day. The resident stated he had felt strange, off, and was staring at the ceiling another day and indicated he believed he was not getting nutrition the way he should have.

Interviews and the resident record indicated the resident had issues with feeding contents backing up into the gastric drainage prior to and following the incident which were not the result of a connection error and did not align with the timeline of events for when the residents change in cognition occurred.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
After the error the facility re-educated, and competency tested all ULP staff to ensure they knew how to properly connect the resident's gastric and feeding tubes. The facility labeled the tubes and implemented a process for 2 staff verify the resident's gastric connection. Nursing implemented monitoring/documenting of the resident's daily intake and output (gastric drainage, and urinary output).

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On November 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL315576485M/#HL315579783C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	